CCC MINUTES APRIL 24, 2015:

Rep. Johnson presented the letter sent from MAPOC to legislative leadership re the Duals Initiative, and potentially what funding realistically might be needed.

Mercer will have revised PMPM based on new risk stratification for new proposal to CMS. Mercer will use a 5 tier and then 3 tier risk stratification. There isn't quite alignment with CMS definition of who is in population. They want levels 1 & 2 removed as well as level 3 which would leave very few people in demonstration. State wants to remove levels 1 & 2. CMS only wants to focus on the highest risk based on the savings they wanted, and it was primarily Medicare savings.

Mercer's original savings projections did not disaggregate the rebalancing initiative. Very difficult to pull out HN initiative.

Karen Smith and Mary Ann Cyr from CHNB presented Risk Analysis of updated Medicare and Medicaid for CY 2013 (See Powerpoint).

- All Members excluding Med Advantage—52,864
- All members excluding 1 & 2 = 49,640
- All members excluding first 2 categories and those in nursing homes—37,939
    - Exclusions also included those in ACO (841), almost 6000 not in Medicaid enrollment (other Medicare categories who are partial duals who are excluded in CMS definition)
    - Matt pointed out in 2013 only 3 ACOs, and now there are 21 ACOs. Number of duals in ACOs could be higher. Kate indicated that ACO attribution is retrospective.
- Did not have Medicare financial claims but had crossover to Medicaid claims. So CHN has utilization but not cost. Mary Ann clarified that cost doesn't figure into risk calculation as much as utilization. Ellen expressed concern that some other factors might be over weighted. Medicare D data is from private plans who aren't required to disclose data.

Risk Methodology based on Johns Hopkins Adjusted Clinical Group System logic. Risk Score represents cost expectation of individual compared to average population. Karyl Lee Hall was concerned about weighting of factors and what this relative weighting is. Mary Ann Cyr that algorithms are proprietary, but **CHN can find out some basic assumptions and follow up**. CHN has used this model successfully for many years to target high risk patients or to low and moderate risk for prevention. Providers have been very involved in developing model and interacts with national quality measures and standards.

- Population is 55.3% under 65 and 44.7% over 65. Predominantly members were in risk categories 3-5. Diagnosis, age, gender entered into date base along with types of conditions and utilization. Costs don't get factored into utilization. Total risk score does account for total costs of population. Goal with high risk people with very complex problems (renal failure, e.g.) is to maintain. Savings may be realized with lower risk populations. What providers get is linked to risk score.
    - Sheila asked if CMS has done their own risk bands, and Bill said they have but state hasn't seen these.
- When levels 1 & 2 excluded, some minor changes in risk scores since so few were in these lower categories. CMS may regard this as insignificant. If HNs only for 4 & 5 risk level, others would be moved to ASO management. Issue is if this is large enough population for a pilot.

- Removing SNF members, total is reduced to 37,939. Average risk score of SNF population is somewhat lower than average of full population because a few drive up the cost in level 5. Molly commented that the sickest people do not use the ancillary services such as PT which add to cost.
    - By removing SNF members, this is primarily Medicaid. Matt suggested possibly looking at level 3 in terms of moving them into another category, retaining some of these in higher risk based on defensible measures. Ellen suggested that we should consider keeping level 3 in nursing homes in.
    - Siobhan Morgan commented that many of their clients moving out of nursing homes are high risk as compared to MFP moving people from nursing homes who are lower risk.
    - Some clients showing in Medicare D who would be in transition to HUSKY C.
    - Questions raised about "neuroses" as a category of diagnosis that shows up as top medical condition—"neurosis" is a specific diagnosis.
    - If state only focuses on risk levels 4 & 5, Bill Halsey asked if this was doable. Sheila suggested that the numbers are high enough for possible pilots in urban areas where larger numbers of dually eligible people are located
    - Sheila suggested that we combine the May and June meetings until after session is over and have presentation on the intersection of substance use and chronic health conditions and the current initiatives underway in the state. Ellen also suggested we focus on requirements and measures for care planning for Health Neighborhoods and will further refine how this might be approached. Sheldon talked about autism services—concerns have been raised about services for both under and over 21. Sheila noted we need to look at overlap with BHPOC. Rep. Johnson said we need to be concerned about transitional services. Rep. Johnson said PRI had forum on sustainable state spending, e.g., moving people from nursing homes to community based on Blum Shapero report. Rep. Johnson will give us a copy. Sheila also suggested health and homelessness intersection and costs.

Next meeting on Friday, June 19. Executive committee will meet to discuss other topics. June meeting as framing meeting for people with complex health care conditions and substance use. How is DSS beginning to define this population, what interventions and in what settings—Dawn Lambert/MFP, CCT teams, VO report. Bill will be prepared for executive committee.

Autism: Sheldon focused on ASD services—what is nature of population? Who is responsible? Sheila raised about DD population and what costs and interventions? DSS is zeroing in on this, and DCF on kid side. Rep. Abercrombie co-chairs autism advisory group and issue of people with limited intellectual capacity; has anyone focused on the overall healthcare and total costs and problems with care? Autism Spectrum Disorder Committee—autism feasibility report recommended this.

Submitted by,

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